DELIVERING INCLUSIVE SERVICES FOR YOUNG TRANSGENDER AND GENDER DIVERSE PEOPLE:

A TRAINING MODULE FOR

Healthcare workers

YouthLEAD

Delivering inclusive services for young transgender and gender diverse people:

A training module for healthcare workers

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ACKNOWLEDGEMENT

This module was developed by Youth LEAD, a network of young key populations in the Asia-Pacific, in partnership with the Asia Pacific Transgender Network (APTN) under the Trans Asia-Pacific and Africa Solidarity (TAPAS) Consortium funded by the Robert Carr Fund (RCF). The module aims to support healthcare workers, including those with non-formal educational backgrounds, to use the right mind and skillset to deliver inclusive care for young transgender and gender diverse people. This module was designed to comprehensively sensitize healthcare workers on the needs of trans and gender diverse people, particularly those who are younger in age.

This module will be integrated into Youth LEAD's new Regional Healthcare Worker Sensitisation Manual on Young Key Populations. It can also be used independent of the Manual for specific training on inclusive healthcare services for young trans and gender divers people. The module was developed through an evaluative process that brought authors and key community leaders together. Our deepest gratitude to all representatives who played an instrumental role in creating and adapting this module.

Several organizations have made significant contributions to the development of this module, notably Youth LEAD, APTN, and Inti Muda Indonesia. We extend our gratitude to all the committees, experts, and leaders who were instrumental in the creation of this module and the pilot workshop conducted in December 2023. Special thanks go to Leo Villar, Communication and Project Management Officer at Youth LEAD, for his exceptional project management and leadership. We also wish to express our appreciation to the participants of the pilot workshop, who represented both the transgender community and healthcare workers (names listed internally). Additionally, we acknowledge the dedicated committees from Inti Muda, including Agatha Syailendra Hamdan, Bella Aubree, Hanam Tyara Treechada, and Turip, for their invaluable contributions.

We encourage more healthcare workers to take more leadership and participate in delivering inclusive healthcare services and programs, designed not only for HIV response, but also for equality, justice, and rights as a concrete reality.

For more information about the module, contact Youth LEAD:
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BACKGROUND

Young people aged 15-24 accounted for two out of every seven new HIV infections worldwide in 2019. While there has been a 46% decline in new HIV infections among this age group over the past decade, global efforts are still falling short of meeting the targets set for young people. Progress has been uneven, with some countries in Asia and Africa lagging behind. More needs to be done to address the structural factors that increase the vulnerability of young key populations to HIV (UNAIDS, 2021).

At the intersection of vulnerability are young transgender people. Recent prevalence estimates based on a systematic review published in 2021 showed that trans women are 66 times more likely to have HIV, with trans men nearly seven times more likely (Stutterheim et al., 2021). However, there is limited understanding of the global burden of HIV and other STIs among transgender populations, as they are rarely identifiable in national surveillance systems. Generally, estimates of individuals identifying as "transgender" range from 0.3% to 0.5% among adults and from 1.2% to 2.7% among children and adolescents. In Asia, a sample of 14,798 people showed a general HIV prevalence of 13.5%, highlighting the scope of the problem (Stutterheim et al., 2021; Zhang et al., 2020).

In the Asia-Pacific region, young trans people are vulnerable to discrimination and abuse, affecting their ability to access proper healthcare and social services. The partnership between Youth LEAD and APTN for the project, “Transcending Borders: Strengthening trans and gender diverse movements towards transformative leadership, legal protection and trans-competent healthcare in the Asia-Pacific and Africa” funded by the Robert Carr Fund (RCF), produced a quick assessment in the year 2022-2023 around the healthcare inclusion of transgender youth in Indonesia, Thailand, and the Philippines. The study showed that most respondents underwent hormonal therapy without medical supervision, with the average commencing hormonal therapy at 21 years old. Many trans youth resorted to their peers (44.12%; n=34) and the internet (38.24%; n=27) for information on hormonal therapy. The DIY use of hormones reflects the challenges of access to quality care. This further suggested the need for capacity building and campaigns for the community (particularly the young population) and healthcare workers around gender affirming care (Wolter & Hegarty, 2022).

Previously, to address the challenges faced by young key populations in accessing inclusive services, Youth LEAD, with support from the Global Fund Multi-Country Grant (SKPA) and UNAIDS RST, developed the "Regional Healthcare Worker Sensitisation Manual for Young Key Populations." The manual aimed to increase the capacity of healthcare workers to provide sensitized services to young key populations was piloted in Cambodia, Indonesia, Papua New Guinea, and the Philippines, and was positively received by government and community representatives (UNAIDS, 2022b, 2023).

In the same vein, Youth LEAD created this module as a reflection of interest and need, based on study and previous experience, to further support the needs of transgender and gender-diverse communities, particularly young people. This module was created as an extension to the healthcare workers training manual previously published by Youth LEAD and is meant to complement healthcare workers with sensitized information specific to the young trans and gender-diverse populations. This strategy will enhance the quality and strength of the manuals, ensuring that no one is left behind.

OBJECTIVES

This module is designed to:

1. Highlight barriers and challenges hindering young trans and gender diverse people from accessing healthcare services,
2. Sensitize healthcare workers on the needs of young trans and gender diverse people,
3. Increase healthcare workers' capacity to deliver inclusive services for young trans and gender diverse people.

METHODOLOGY

The creation of this module comprises several methodologies

1. **Desk review**

Desk review of the most relevant source of information in relation to transgender health; with specific keywords on transgender youth, transgender young people, gender-affirming care, HIV/STIs, sexual reproductive health and rights, mental health, discrimination, and healthcare system in the Asia Pacific.

2. **Community consultation and input**

This module was developed in tandem with Youth LEAD focal points, which consist of young community leaders coming from various key population groups. The input was received from focal points and was implemented into the creation of this module and its pilot implementation.

3. **Pilot delivery**

Pilot delivery was commenced in 2 December 2023, in Jakarta, Indonesia, with a total of 42 participants coming from the transgender community and healthcare workforce. Feedbacks were gathered orally during the pilot workshop[1], as well as written through Google Forms, with proper meeting minutes.

[1] In this module, we will use the terms "workshop" and "training" interchangeably. However, there will be a tendency to use "training" to describe the overall process, while "workshop" will specifically refer to the activity that is being held or will be held to deliver the training.

PREPARATORY STAGE

PREPARATORY STAGE

What to prepare	Description
Coordination process	Coordination is crucial to ensure the training process adheres to the module and agenda. It's important to coordinate with local partner organizations and discuss training needs before the training or workshop process begins. By securing strong buy-in from counterparts, the purpose and value of the training are reinforced.
Number of days	The module's content has been designed for a one-day sensitization workshop to accommodate healthcare workers' busy schedules. This could be done during weekdays or weekends, depending on the availability of time, continued with follow-up actions on independent adult learning.
Participants	This module implementation could accommodate up to 30 participants for a full day workshop and has been tested during the pilot. To go beyond 30 participants is not advised, as some of the module sessions might require intense interaction. Make sure that the invited representatives are gender-balanced, professional/role-balanced, and as diverse as possible. Community representatives could be recruited from health or rights-related organizations, to make sure the relevance of the module.
Preparing facilitators and co-facilitators	Facilitators are key persons who have knowledge and skills related to the health of young transgender people, with a specific focus on their ability to deliver interactive and productive sensitization training. Co-facilitators should have similar experiences and knowledge to support facilitators during the workshop implementation. Depending on the experience, this module can strategically be delivered by 1-2 individuals.

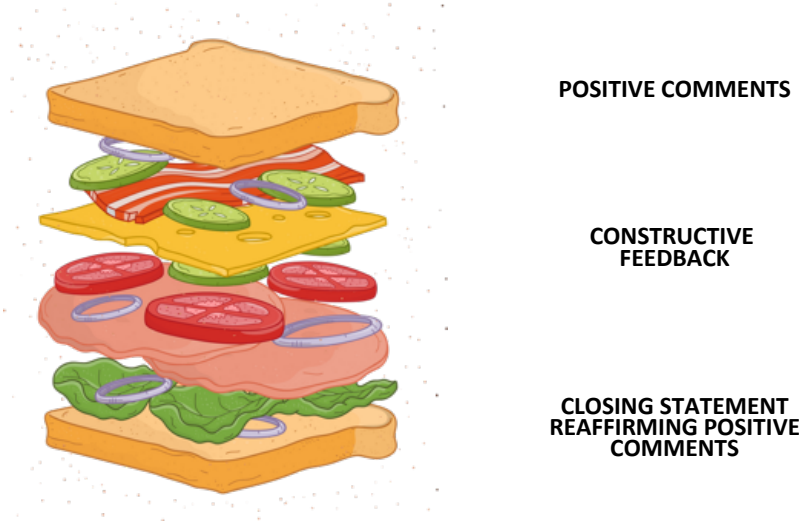
Stakeholders and invitees	It is important to know your target groups. Healthcare workers consist of several different professions and jobs. While it is crucial to invite key decision makers in patient-provider interaction, such as doctors, nurses, and psychologists, this module can be used to sensitize other healthcare workers who work in a healthcare facility; adjusting to the needs of the institution. Some of the healthcare workers that we can invite include doctors, psychologists, nurses, midwives, pharmacists, laboratory technicians, physical therapists, administrative staff, and more.
Venue management and equipment	Arrange the furniture and room (adjusting to the number of participants) for more accessible movement for activities and games. Ensure that the venue and staff are informed about the type of training you will conduct to guarantee that all participants across different expressions and backgrounds feel safe. Also, ensure that the right technical equipment, for example, microphones, speakers, projector, screen, and Wi-Fi connection, are available.
Registration process	With a simple registration form (e.g. through Google Forms), several administrative concerns could be accommodated, namely the number of participants, the need for an interpreter and sign language, and more. It is advisable to send the invitation 1-2 weeks before the workshop starts, to accommodate participants' needs and other necessary adjustments. Additionally, the in-person registration is crucial, to reflect on those who actually attended the training.
Interpreter and sign language	Prepare the language and sign language interpreters, if needed. Seek professional interpreters who were sensitized to LGBTIQ+, HIV, and key population issues. If there are limited resources and if possible, ask for other participants to help with interpretation.
Evaluation process	Evaluation is essential for assessing and measuring the progress of training. It can be flexibly designed to cater to the needs of the training process. Typically, pre- and post-tests are conducted to document progress. For instance, an evaluation survey can help capture the increased level of awareness. Organisers can also identify areas for improvement in the logistics, facilitation process, module content, and more. Additionally, evaluations might encompass future action plans to determine what participants plan to do following the workshop.

TECHNICAL KNOWLEDGE, SKILLS, AND SENSITIVITY ISSUES

What to prepare	Description
Goals and expectations	While learning is a dynamic process, it is important to set clear expectations for the training. This module is designed to sensitize healthcare workers on issues related to the health and well-being of young transgender people. At the end of the session, participants are encouraged to engage in adult independent learning to gain a deeper understanding of transgender health and its intersection. This module can also be used to complement the "Regional Healthcare Worker Training Manual for Friendly HIV and SRHR Services for Young Key Populations in the Asia Pacific," developed by Youth LEAD in 2021.
Safe space and privacy consideration	By knowing the participants' backgrounds, we could predict the group dynamics and take necessary precautions. Be respectful of every background. During the introduction session, it is crucial to develop ground rules in the group. Everyone is encouraged to be respectful, avoid negative conversations, and keep private things private after the workshop. Fairly ask the participants if they would consent to be photographed or recorded during the session.
Core principles	Some examples of core principles that need to be reflected in the training delivery process are:- Respect for diversity,- Do no harm (avoid exposing people to additional risks through our actions),- Privacy (what can be shared vs. cannot be shared),- Active participation,- Listening with empathy and care.
Knowledge	Preparation prior to the training is crucial. Facilitators need to be prepared with technical questions around the key areas of gender, sexuality, and health. Key learnings should be addressed properly during each debriefing session at the end of each session. Set a clear difference between opinions/assumptions and evidence. If you do not know the answer, be transparent and propose a way to search for evidence.

Methods of delivery	This module comprises a participatory and experiential style of information sharing using games, presentations, and role-play, with the purpose of building a friendly, energising, and safe space. While it is ideal to prepare the materials and methodologies before the training starts, there might be cases when improvisation is needed, and when it happens, flexibility is key.
Communication and listening (active and reflective)	Give clear instructions and repeat them if needed. Make sure that everyone can hear each other clearly and ask for clarification when feeling unsure. Use the kind of language that your participants will understand. Both active and reflective listening are key. Active listening shows that the listener is hearing what the person is saying and acknowledges the person speaking. Reflective listening involves the listener reflecting back on what the speaker is saying. Reflecting can involve reflecting on the words the person used or reflecting on the feeling that the person used. Do not be afraid to recheck statements, such as, “You have pointed out that we have very little data on this issue, is that what you were saying?”
Participation	It is crucial to make participants feel they are involved and belong. Building and maintaining positive group relationships through our positive expressions (smile, welcoming gesture) and words (thank you, encourage people to express ideas). Through group observation, make sure no one feels left out, organise seating/group dynamics.
Conflict management	Facilitators should create an atmosphere where each participant feels free to share different opinions and agree to disagree. When dealing with different views, facilitators should provide evidence-based information, facilitate discussions, summarise, and ask participants to think about the possible consequences of each action. While it is okay to have different opinions, it is core to differentiate them from hate speech by having common ground on human rights and ethical principles (United Nations, n.d.).

Time management	It is important to keep things on-time throughout the facilitation process. If possible, let the participants know the duration of each activity and adjust the timing based on participants' needs and group dynamics. Make sure the adjustments will not change the aim of the training process.
Stress and trigger management	When discussing sensitive subjects, some participants might be triggered. Avoid this by checking the methodology and list of questions addressed throughout the training process. Facilitators should be sensitive enough to be aware of such possibilities and do risk management to handle triggers and stress, such as providing information to local mental health professionals, or utilising breathing relaxation techniques (NHS UK, 2021): • If you're sitting or standing, place both feet flat on the ground. Whatever position you're in, place your feet roughly hip-width apart. • Let your breath flow as deep down into your belly as is comfortable, without forcing it. • Try breathing in through your nose and out through your mouth. • Breathe in gently and regularly. Some people find it helpful to count steadily from 1 to 5. • Then let it flow out gently, counting from 1 to 5 again, if you find this helpful. Provide information on referrals for psychological and medical support in the area, and list out contacts of hospitals, clinics, and other facilities relevant to the needs.

Feedback and input	It is necessary to ask for feedback. Some activities in this module suggest participative feedback. Feedback can be gathered orally during the training session and written (e.g. through Google Forms). Share your feedback in a respectful manner and with clarity on specific things you want to improve. You can follow the sandwich approach when providing feedback, consisting of positive comments, constructive feedback, and the closing statement (reaffirming your positive comments)  Sandwich approach in providing feedback
References	It is highly recommended to use evidence-based information throughout the training, such as: *https://www.wpath.org/* *https://weareaptn.org/resources/* *https://www.youthleadap.org/* *https://www.who.int/health-topics/gender* *https://www.unaids.org/* *https://www.aidsdatahub.org/* *https://www.unfpa.org/hiv-aids* *https://www.cdc.gov/hiv/default.html*

CORE TRAINING DELIVERIES AND MATERIALS

SESSION 1 - INTRODUCTION

Activity 1: Welcome introduction

Objective	To introduce participants and facilitators.
Estimated time	20 minutes.
Tools	Name tags or lanyards, marker pens.
Method	Discussion and sharing.
Online alternative	If the workshop is conducted virtually, the training can omit the equipment needed. Ask the participants to change their username to name, pronoun, and affiliation, then introduce themselves.

Steps:

1. The facilitators open up the session by introducing themselves. Participants are requested to write the following information (Name, pronoun, affiliation/organization) on their lanyards.
2. They should be asked to read out their written information as an introduction, alongside additional information, such as hobbies or favorite cuisines.
3. Note that each person should take 30 seconds for their introduction.
4. After everyone has introduced themselves, facilitators should explain the objectives of the workshop and its flow.

Activity 2: Walls of hope

Objective	To set goals and expectations for the workshop and training process.
Estimated time	15 minutes.
Tools	Flip charts, sticky notes, marker pens.
Method	Discussion and sharing.
Online alternative	Online workshop can utilize tools such as Mentimeter and/or Jamboard or Miro to record the goals and expectations of participants.

Steps:

1. Participants are instructed to spend 3-5 minutes writing down their expectations and goals for the workshop on sticky notes.
2. Participants are expected to put their sticky notes on three charts, answering three key questions:
   a. What do you want to learn? 
   b. What do you want to feel? 
   c. What actions do you want to take?. 
3. Facilitators will read out and cross-check who shares similar expectations, asking those who have heard a similar response to show hands to indicate that they share those expectations and goals.
4. Explain that establishing clear, shared goals is an integral part of the work of leadership. When group members work together to set, clarify, or reconnect with their goals, they are more likely to work effectively as a team.

Activity 3: Establishing ground rules

Objective	To set ground rules for participants to agree on.
Estimated time	15 minutes.
Tools	Flip charts, marker pens, a stuffed toy or ball.
Method	Discussion and sharing.
Online alternative	Online training can utilize tools such as Mentimeter, Jamboard, and Miro to document the ground rules.

Steps:

1. Ask the participants to stand and form a circle. The facilitator holding the stuffed toy or ball will begin by suggesting one ground rule with an explanation and tossing the stuffed toy or ball to any person within the circle.
2. The next person who catches the stuffed toy or ball will be the next to suggest a ground rule and explain it.
3. Write down the ground rules on the flip chart.
4. Do the activity until there is a sense that the ground rules have been made, reflecting on the core principles of this training process.

EXAMPLES OF GROUND RULES

- Active participation.
- Be on time and ready to learn.
- Respect for diversity, including pronouns, languages, opinions, and other attributes.
- Maintain confidentiality and privacy, including personal sharing and disclosure.
- No one is expected to disclose any information about themselves that they do not wish to share.
- Protect safety during games and activities.
- All mobile phones should be in silent mode or turned off during the training.
- Listening with empathy and care.

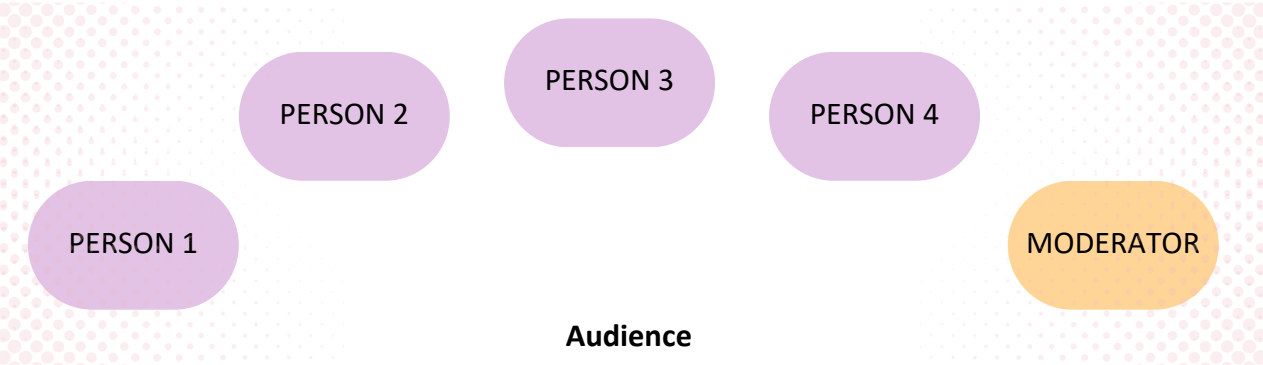
SESSION 2 - GETTING COMFORTABLE AROUND GENDER AND SEXUALITY: HOW CAN WE RECOGNIZE DIVERSITY?

Activity 4: SOGIESC show: Understanding self, am I proud of who I am?

Objective	● To understand lived experiences and realities of living as a woman, man, trans-, non-binary, intersex person, or any other identities; contextualizing diversity around gender, sex, and sexuality
Estimated time	45 minutes.
Tools	Simple assembly to resemble a talk show stage.
Method	Discussion and sharing through a talk show.
Online alternative	Can utilize online discussion through Zoom, Microsoft Teams, Google Meet, or else.

Steps:

1. Set up the room with five chairs at the front, resembling a talk show stage.
2. Ask up to four participants to voluntarily participate as talk show guests and one facilitator as the moderator. Try to keep the representatives gender-balanced, profession/role-balanced, and as diverse as possible.



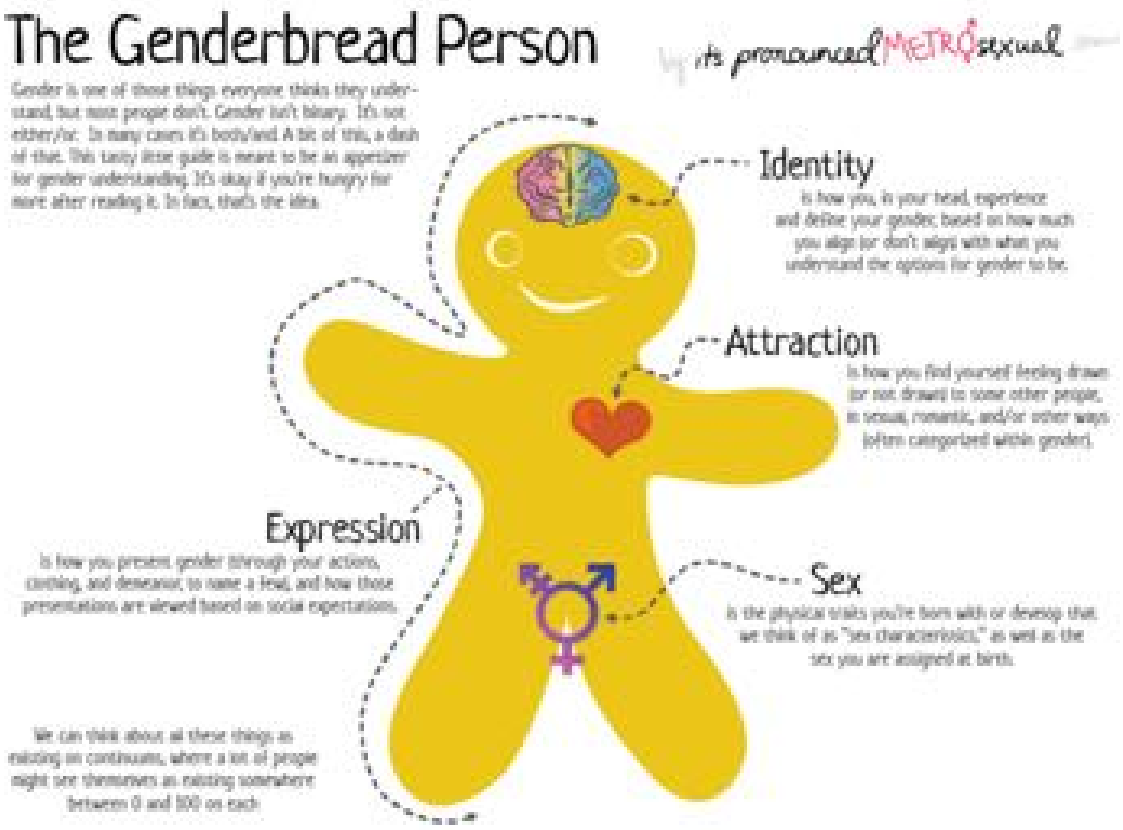
POSSIBLE STAGE ASSEMBLY

1. The remaining participants could serve as audiences and could ask questions or share their thoughts after the talk show.
2. Give the instructions for participants to answer comfortably and rely on the answer to their process of self-exploration and discovery around gender and sexuality.
3. Use 20 minutes for the talk show and 5 minutes for the Q&A.

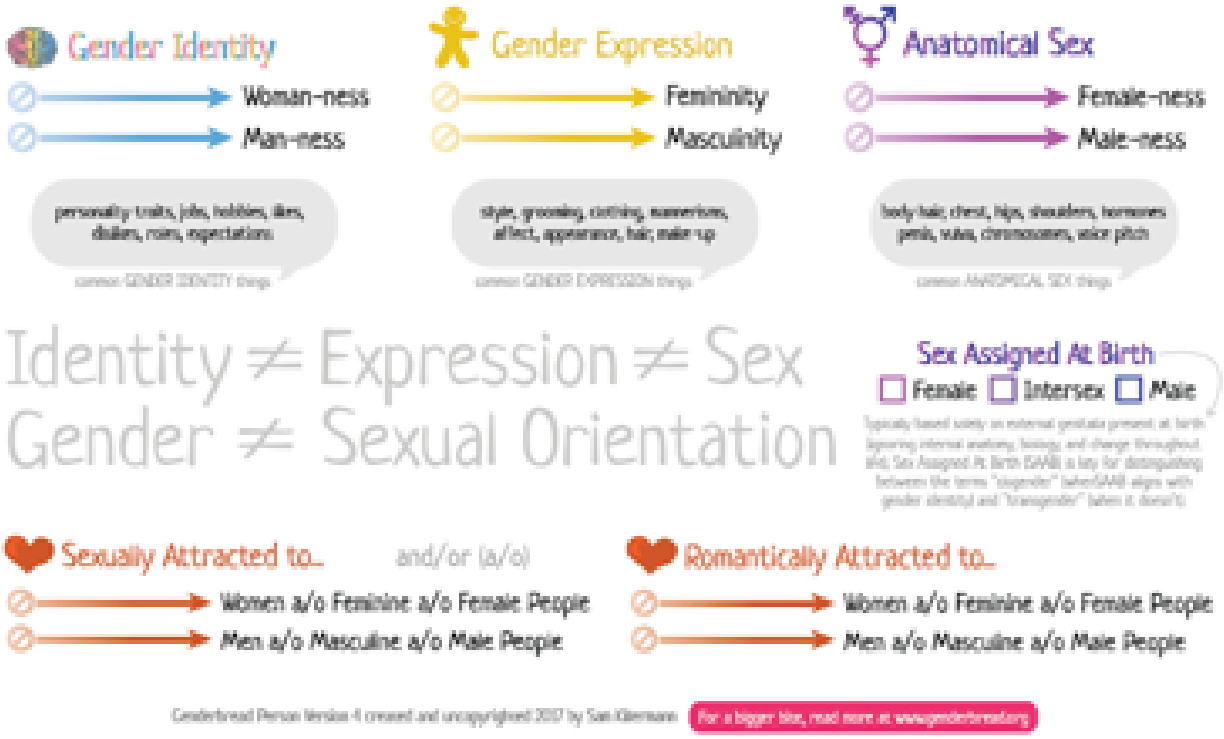
EXAMPLES OF TALK SHOW INTERVIEW QUESTIONS

1. What is your understanding of gender and sexuality?
2. When was the first time you learned the concept of gender?
3. How did you discover your own sexuality, gender, intersex status, or else?
4. Did you encounter certain challenges, and how do you cope?
5. What do you want to say to younger generations or those who are still in the closet?
6. Based on the talk show, discuss with the participants the fluidity of gender, sex, and sexuality. Use open-ended probing questions that cisgender people usually ask a transgender person, such as, “When was the first time you realize that you are a boy/girl” to trigger discussion and let participants share their insights.
7. Gender bread and other relevant visualization guides could be used. Try to explain diversity from a relevant point of view

EXAMPLES OF GENDER DIVERSITY VISUALIZATION



GENDER BREAD PERSON VERSION 4



Bissu in a traditional ceremony in Bone, South Sulawesi, Indonesia. Bugis culture recognizes five genders oroané (man), Makkunrai (woman), Calalai (trans man), Calabai (trans woman), and Bissu (androgynous, gender neutral, or intersex person who became the spiritual leader) (Prasetyo, 2022)

Lakapati, Transgender Tagalog Goddess of Fertility & Agriculture; Photo by brianbarrtt
(Gancayco, 2016)

Activity 5: Understanding intersectionality: What are our social identities?

Objective	• To sensitize participants on their diverse identities and explain how social identities collide with one another and how privilege operates to prefer some identities over others. • To understand more about intersectionality, especially in the context of young trans people.
Estimated time	45 minutes.
Tools	Writing papers as banners, marker pens, duct tape or adhesive, and PowerPoint presentation.
Method	Games, presentation, case discussion, and sharing.
Online alternative	For online users of the training manual, this activity can be adapted as above by asking the participants to write their chosen categories on a blank paper and show it once they are ready to answer, or through Jamboard or Miro.

Steps:

1. Set up the room with different papers as banners of social identity categories based on several characteristics, such as gender (including gender identity), sex, sexual orientation, race, ethnicity, the nation of origin, first language, religion/spirituality, socioeconomic status, age, disability, skin color, body size/type (University of Michigan, 2022).
2. For smaller groups, consider grouping closely connected identities with one another, such as:

Categories	Examples
Gender and gender identity	Man, woman, cisgender man, cisgender woman, transgender man, transgender woman, non-binary, gender non-conforming person.
Sex	Male, female, intersex.
Sexual orientation	Games, presentation, case discussion, and sharing.
Race	Asian, White, Black or African American, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, Hispanic or Latino, and other categories.
Ethnicity	Chinese, Japanese, Thai, Irish, Puerto Rican, Italian, Mohawk, Jewish, European-American.
Nation of origin	Indonesia, Philippines, Thailand, Malaysia.
Caste[2]	Most backward caste (MBC), backward class (BC), scheduled tribe (ST), scheduled caste (SC), forward caste (FC) or general caste, and more (Sankaran et al., 2017).
First language	Melayu, Chinese, Indonesian, English, Tagalog.
Religious/spiritual affiliation	Hindu, Muslim, Buddhist, Jewish, Christian, Pagan, Agnostic, Faith/Meaning, Atheist.
Socioeconomic status	Poor, working class, lower-middle class, upper-middle class, owning class, ruling class.
Age	Child, youth, young adult, middle-aged adult, elderly.
Disability	Persons with disabilities (cognitive, physical, emotional, and more), temporarily able-bodied, temporarily disabled.
Skin color	Brown, yellow, white, black.
Body size/type	Curvy, obese, large, person of size, thin.
Hair type	Straight, curly, and more.

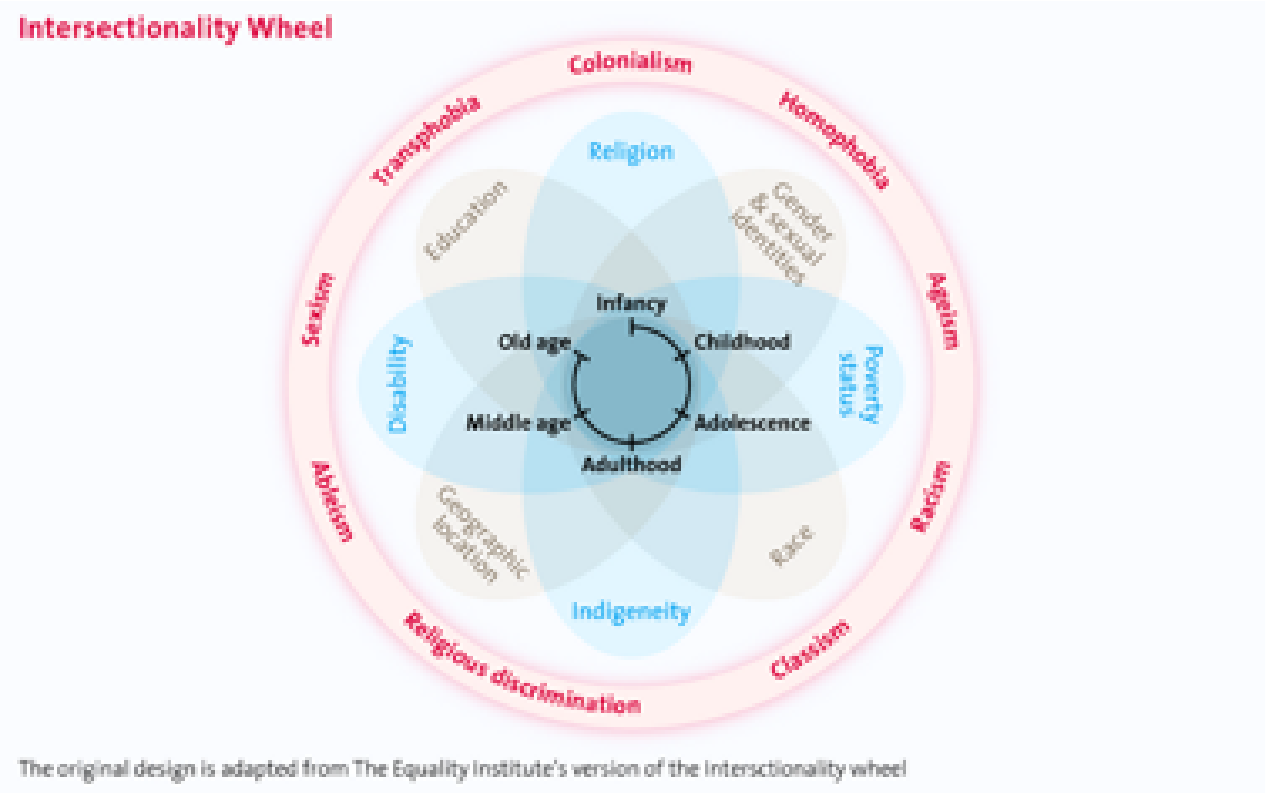
2] The caste system is a traditional hierarchical social structure, often rooted in religious beliefs, that classifies individuals into distinct categories based on ancestry and occupation, with each caste having its own privileges and limitations. For example, in prominent country like India, it historically dictates social roles, marital prospects, and economic opportunities.

3. Read the statements on social identity categories and allow all participants to stand near the banner that they feel connected to the most. Give some time for each participant to self-select the identity that best answers the question. If there is a participant alone in an identity, you can join them in conversation. Questions:

a. What identity has the greatest effect on how others perceive you?
b. What identity has the strongest effect on how you perceive yourself?
c. What identity would you like to learn more about?

4. After each statement, encourage participants to share their thoughts on why they chose that particular social identity category. Priorities should be given to the least active participants in the group.

5. Discuss with the participants the importance of critically reflecting on our social identities and the value of understanding marginalization and privilege using the intersectionality wheel.



Intersectionality wheel - adapted from the Equality Institute's version (UNPRPD & UN Women, 2021).

- Discuss how intersections of marginalization could influence the health and rights of young transgender people (due to intersecting identities based on gender identity and expression, age, socio-economic, race, religion, geographical location, and more).

- Some case studies could be used to trigger discussion around intersectionality. In the below case, it became quite clear the intersectionality faced by Raisya, being poor, young, trans, living in a geographically remote, culturally conservative area, and how it rolled into the reality of young people who sell sex.

CASE DISCUSSION

Raisya is a 25-year-old transgender woman living on a remote island in Indonesia. She always felt different from the age of 4-5 years old and had been experiencing gender dysphoria ever since she could remember. One of her earliest memories was not wanting to wear pants to go to school, and always wanted to wear skirts, in her words, "I want to be like the other girls at school." She was bullied throughout elementary and junior high school due to her feminine behaviors. At home, she was not well accepted by her parents, who became stricter from time to time, worrying that their son might become waria (one of the terms for trans women in Indonesian). Raisya came from a low-income family background with six other siblings.

She quit school at the age of 15, and ran away from home, with the hope of exploring a better life in a big city outside her remote hometown. Through word of mouth, she heard that there were "people like her" in the city and that she could be "transformed into a beautiful woman." Once she reached the city, she met with Mayang, an elderly trans woman who accommodated Raisya in her house. She was advised to use contraceptive pills to make her look pretty, elongate her hair, and start dressing up. She met other trans women in Mayang's house who advised her to do nyebong (the Indonesian trans community's slang for sex work) to get extra money.

The story was based on the author's personal encounter; not the real name and no specific personal, identifiable details.

- Encourage participants to share some of their stories on intersectionality, it could be their own personal journey, or someone they knew.
- Remain reflective and help map out how intersectionality is affecting one's life, linked to the idea of being gender and culturally sensitive and respectful.

SESSION 3 - HEALTH AND RIGHTS OF YOUNG TRANSGENDER AND GENDER DIVERSE PEOPLE

Activity 6: Recognizing challenges to health: Rights of young transgender and gender diverse people

Objective	• To recognize the core concepts of health as human rights and issues around social determinants of health. • To recognize challenges on rights to health for young transgender and gender diverse people.
Estimated time	75 minutes.
Tools	Sticky notes, flipcharts, marker pens, and PowerPoint presentation.
Method	Problem tree creation, reflection, presentation, discussion, and sharing.
Online alternative	This activity can be adapted online through the use of Jamboardor Miro; problem tree templates could be used.

Steps:

1. Start the session with an opening statement, “What does ‘health as a human right’ mean for you?” Ask participants to write down some answers on sticky notes and put their answers on a board.
2. Ask participants to share their reflections with other participants. Reflect together on core concepts of health and human rights. A simple presentation could help guide this process:

WHAT ARE HUMAN RIGHTS?

Human rights are rights we inherently have, because we exist as human beings, regardless of nationality, sex, sexuality, gender, disability, national or ethnic origin, color, religion, language, or any other status. Human rights could range from the most fundamental - the right to life - to those that make life worth living, such as the rights to food, education, work, health, and liberty. Some principles of human rights include:

1. Universal and inalienable; universal means we are all equally entitled to our human rights and inalienable means that our rights should not be taken away, except in specific situations (e.g., the right to liberty may be restricted if a person is found guilty of a crime).
2. Indivisible and interdependent; A set of rights cannot be enjoyed without the other (e.g., making progress in civil and political rights makes it easier to exercise economic, social, and cultural rights and vice versa).
3. Equal and non-discriminatory; Article 1 of the UDHR states: "All human beings are born free and equal in dignity and rights." Freedom from discrimination, set out in Article 2, is what ensures this equality. Non-discrimination cuts across all international human rights laws. This principle is present in all major human rights treaties.
4. Both rights and obligations; while everyone universally enjoys their human rights, obligations must follow. Obligation means that States must refrain from interfering with or curtailing the enjoyment of human rights, with States to protect individuals and groups against human rights abuses and must take positive action to facilitate the enjoyment of basic human rights.

HUMAN RIGHTS-BASED APPROACH TO HEALTH

A human rights-based approach to health focuses on strategizing our attention, strategy, and solution toward inequalities, discriminatory practices (both real and perceived), and unjust power relations, which are often at the heart of inequitable health outcomes. The goal of the human rights-based approach to health (HBRA) is to ensure that all health policies, strategies, and programmes are designed to ensure the right to health and other health-related human rights (safe and potable water, sanitation, food, housing, health-related information and education, and gender), amongst others being fulfilled (OHCHR & WHO, n.d., 2008; WHO, 2016). In defining the right to health, the Committee on Economic, Social, and Cultural Rights further unpacked the key attributes of this right, noting the importance in health settings of availability, accessibility, acceptability, and quality of health services as key guiding principles (OHCHR, 1966; WHO, 2016).

THE RIGHT TO HEALTH

UNDERLYING DETERMINANTS OF HEALTH

Access to minimum essential food, which is nutritionally adequate and safe.
Access to basic shelter, housing, safe and potable drinking water and adequate sanitation.
Education and access to information concerning the main health problems in the community, including methods of preventing and controlling them.
Promotion of gender equality.

A
Availability

A
Accessibility

A
Acceptability

Q
Quality

HEALTH CARE

Right of access to health facilities, goods and services on a non-discriminatory basis, with attention to vulnerable and marginalized groups.
Equitable distribution of all health facilities, goods and services.
Provision of essential drugs, as defined under the WHO Action Programme on Essential Drugs.
Participation of affected populations in health-related decisions at the national and community levels.

AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY AND QUALITY

Availability: functioning public health and health-care facilities, goods, services and programmes in sufficient quantity

Accessibility: non-discrimination, physical accessibility, economic accessibility (affordability), information accessibility

Acceptability: respectful of medical ethics, culturally appropriate, sensitive to age and gender

Quality: scientifically and medically appropriate

The right to health (WHO, 2011)

Box 4 Key principles of a human rights-based approach to health

A human rights-based approach

• **Non-discrimination and equality**: Health services, goods and facilities must be provided to all without discrimination. All individuals are equal as human beings and by virtue of their inherent dignity. All human beings are entitled to their human rights without discrimination of any kind on the grounds of race, colour, sex, ethnicity, age, language, religion, political or other opinion, national or social origin, disability, property, birth or other status. In the instance that development programmes cannot reach everybody at once, priority must be given to the most marginalized.

Programming must help to address underlying and systemic causes of discrimination in order to further genuine and substantive equality.

- **Participation:** There must be meaningful opportunities for engagement in all phases of the programming cycle: assessment, analysis, planning, implementation, monitoring and evaluation.

- **Accountability:** Mechanisms of accountability are crucial for ensuring that the State obligations arising from the right to health are respected. Accountability compels a State to explain what it is doing and why and how it is moving, as expeditiously and effectively as possible, towards the realization of the right to health for all. The right to health can be realized and monitored through various accountability mechanisms, but at a minimum all such mechanisms must be accessible, transparent and effective.

General Comment 14

- **Availability:** Sufficient quantities of public health and health-care facilities, goods/ services and programmes.
- **Accessibility:**

1. Physical accessibility - safe physical reach (especially in rural areas);
2. Information accessibility - ability to seek, receive and impart information and ideas concerning health issues and to protect health data; Accessibility also implies the right to seek, receive and impart health-related information in an accessible format (for all, including persons with disabilities);
3. Non-discrimination; and
4. Economic accessibility - financial affordability.
5. Accessibility also implies the right to seek, receive and impart health-related information in an accessible format (for all, including persons with disabilities).

- **Acceptability:** Respectful of medical ethics, informed consent, patient confidentiality, and cultural appropriateness. The facilities, goods and services should also respect medical ethics, and be gender and age sensitive and culturally appropriate and acceptable.
- **Quality**: Services, goods and facilities must be scientifically and medically appropriate and of good quality. This requires, in particular, trained health professionals, scientifically approved and unexpired drugs and hospital equipment, adequate sanitation and safe drinking-water.

Sources: CESCR, 2000; CESCR, 2003; WHO, 2013b; WHO, 2014.

Key principles of HBRA (WHO, 2016)

3. After the explanation, ask the participants to reflect on the context of young trans and gender diverse people; while it is clear that everyone deserves a healthy life, as part of their rights to health, some challenges still persist, particularly for vulnerable groups.
4. Divide the participants into smaller groups. Ask the participants to create a problem tree or social ecological model to map out the challenges faced by young trans and gender diverse people in the context of fulfilling their rights to health, for example, based on several classifying themes:

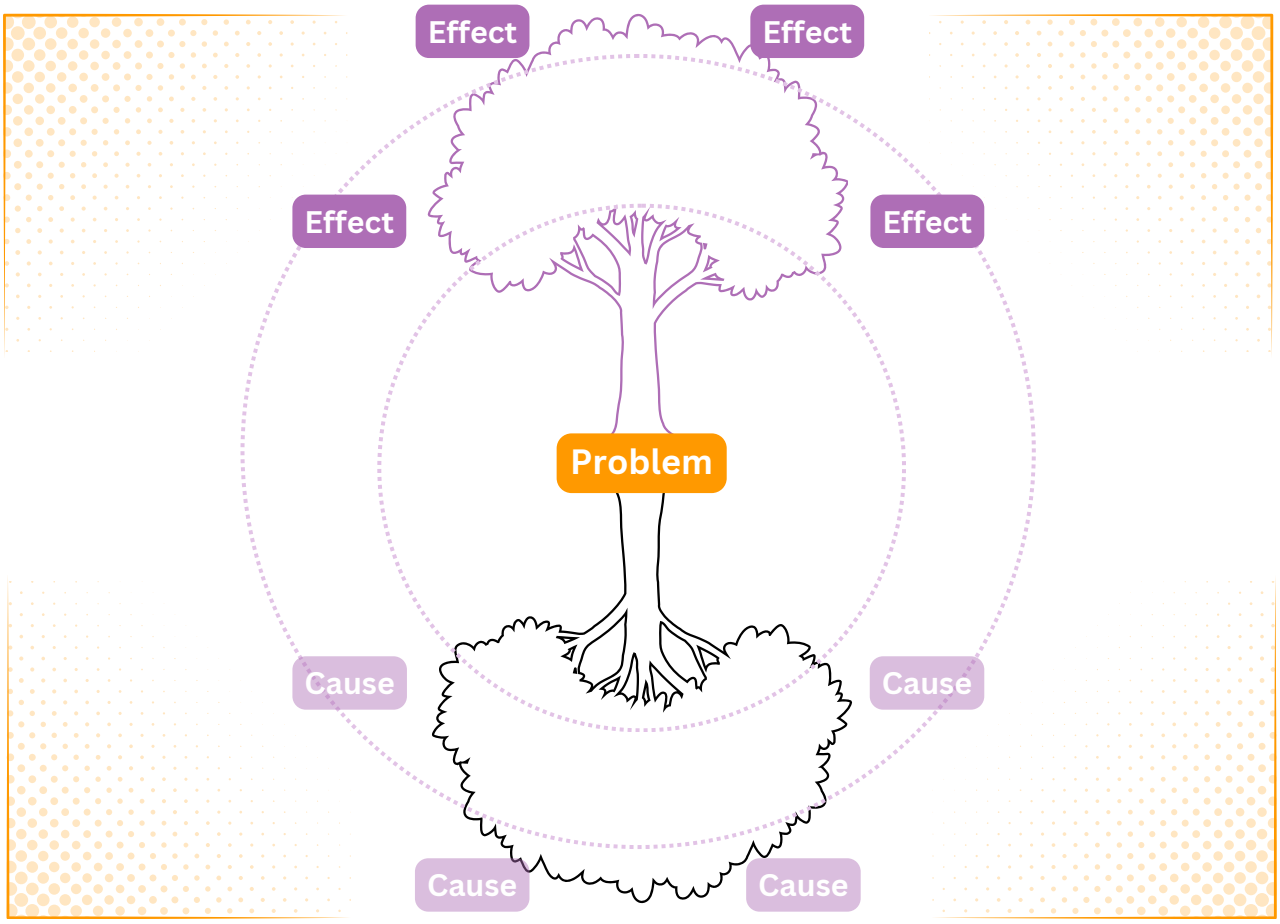
Examples of themes	Examples of methods
Challenges to optimum physical and mental health (e.g., high physical health burden, HIV, high mental health burden, depression, anxiety, trauma)	Social-ecological model
Challenges to gender affirming care (e.g., hormones, surgeries, social intervention)	Problem tree
Challenges to legal gender recognition and protection against violence (e.g., name, legal gender marker, physical/sexual violence, and more)	Problem tree

5. Explain briefly how to create a problem tree or social ecological model to the participants

CREATING A PROBLEM TREE: CHALLENGES ON HEALTH AND RIGHTS[4]

Problem tree could be branched into three core areas (Evaluation Toolbox, 2010):
A. Cause of the problems; explore the root causes of health inequalities faced by trans and gender diverse people (e.g., due to direct and indirect discrimination, pathologization, unavailability, misunderstanding, patriarchy, homophobia-transphobia, and more).
B. Problems; problems that emerge from the root causes (e.g., health inequalities).
C. Effects from the problems; impact of health inequalities that emerge as a result of failure to uphold rights to health (e.g., in the forms of high HIV/STIs burden, suicide rates and mental health problems, poor overall health outcomes, short life expectancy, and more).

[4] The AAAQ approach could be used to guide the process, especially for the impact or effect, caused by the problems.



Example of a problem tree structure

CREATING A SOCIAL-ECOLOGICAL MODEL: CHALLENGES ON HEALTH AND RIGHTS[5]

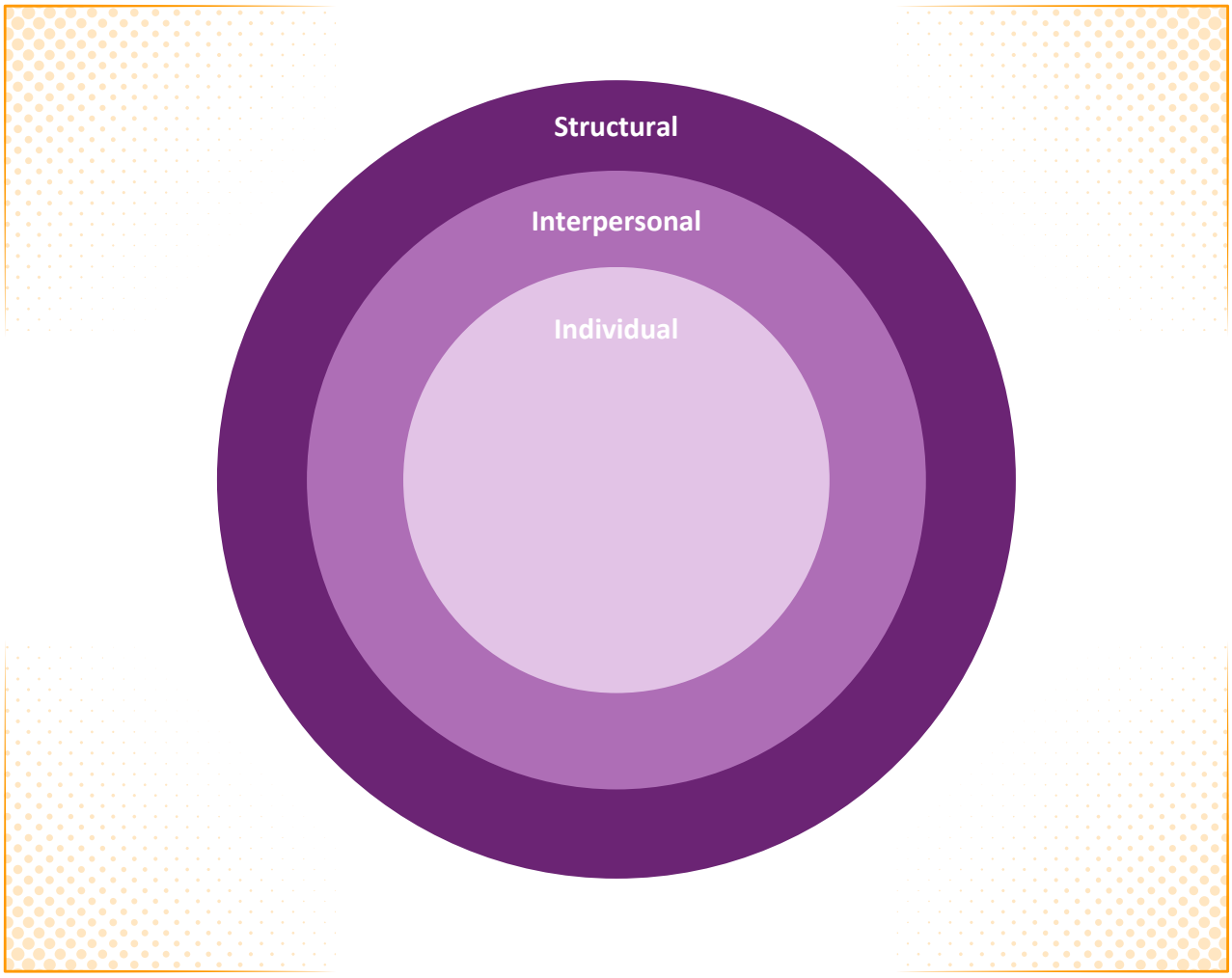
A. Ecological model shows how an individual's life is affected by their surroundings, namely (White Hughto et al., 2015):

B. Individual; individual factors, beliefs, behaviors (e.g., individual mental and physical health challenges, internalized stigma, and more).

Interpersonal; everyday interaction (e.g., family rejection, school bullying and violence, workplace discrimination, healthcare discrimination, hate crimes, violence).

C. Structural; societal norms, values, conditions, laws, policies, and practices (e.g. stigmatizing and discriminating policies and practices, broader structural barriers to health and rights, unjust legal system, gender inequality, economic inequality, educational barriers, structural oppression of minorities, and more).

[5] The AAAQ approach could be used to guide the process of identifying individual, interpersonal, and structural barriers in the social-ecological model.



Example of social-ecological model

6. Ask each group to present their problem tree or social ecological model. To remain time efficient, ask the participants not to repeat the same information shared by the previous group, but to add new information or opinions while presenting.
7. During the discussion, provide feedback effectively to enrich the understanding of health and rights for young trans and gender diverse people.
8. Close the session by concluding and explaining the social determinants of health, linked up to the discussion process.

SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDH) encompass the circumstances of an individual's birth, growth, employment, living conditions, and aging process, as well as the broader forces and systems that mold these life conditions. These include but are not limited to economic structures and policies, agendas for development, societal norms and regulations, and political institutions. SDH is considered changeable and, therefore, suitable as targets for policies and programmatic interventions promoting health equity. Therefore, a comprehensive understanding of and approach to health needs to include tackling these social determinants and addressing health inequities:

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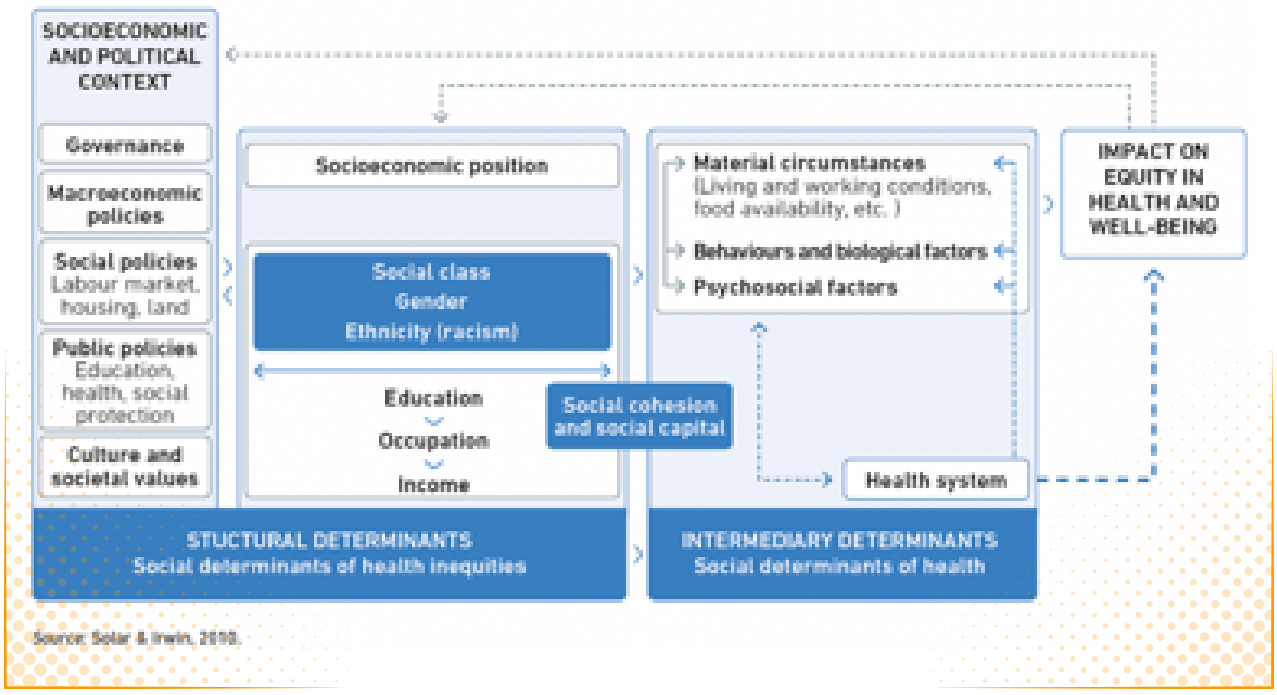
1. Mechanisms of health inequities and structural determinants (the true origin of health inequities):
    a. Socioeconomic and political context (governance, macroeconomic policies, social policies, public policies, culture/social values).
    b. Socioeconomic position and sociocultural factors (social class, gender, ethnicity + education, occupation, income).
2. Intermediary determinants:
    a. Material circumstances (e.g. housing and living conditions, working conditions, food availability).
    b. Behavioral factors (e.g. smoking, diet, alcohol, exercise, risk-taking behaviors).
    c. Biological factors (e.g. genetics).
    d. Psychosocial factors (e.g. psychosocial stressors, fear of violence, gender-based violence, restricted decision-making autonomy, roles, and relations).



SOCIAL DETERMINANTS OF HEALTH (WHO, 2010, 2016)

In the context of the transgender population, many trans and gender diverse people experience stigma, prejudice, discrimination, harassment, abuse and violence, resulting in marginalization (social, economic, health, legal) and even death—a process that has been characterized as a stigma-sickness slope (Winter et al., 2016). Experiences such as these lead to minority stress (Meyer, 2003), and are associated with poor health outcomes (Coleman et al., 2022).

Violence against trans people has a considerable wide global impact with its diverse nature (emotional, sexual, physical, and more) and perpetrators (including State actors). Statistics on murder, the form of violence most extreme in its consequences, are alarming (Coleman et al., 2022; Mujugira et al., 2021). Worldwide, there were over 4,000 documented killings between January 2008 and September 2021; a statistic widely regarded as flawed by under-reporting (Fedorko & Kurmanov, 2021).

Activity 7: Inclusive care and affirming services for young transgender people: History and current reality

Objective	● To understand the notions and needs for gender affirming care, as part of the human rights of young transgender and gender diverse people. ● To recognize the positive impacts of having affirming and gender inclusive spaces for young transgender and gender diverse people.
Estimated time	75 minutes.
Tools	Relevant drama props and PowerPoint presentation.
Method	Drama, reflection, presentation, discussion, and sharing.
Online alternative	For online users of the training manual, this activity can be adapted as above by asking the participants to do their drama on the video screen. Divide participants into breakout rooms during preparation time.

Steps:

1. Divide the participants into two large groups. Ask the participants to play a drama, representing a distinct scenario of what it means to have inclusive vs. non-inclusive care for young transgender and gender diverse people.
2. Give participants time to prepare and present their drama play.
3. Encourage participants to think creatively about their drama scenario and use possible stage props if available; the role, scenario, and more.

Examples of scenario, with some notes from WPATH SOC-8 (Coleman et al., 2022)

Examples of drama scenario	**Examples of inclusive care characteristics**	**Examples of non-inclusive care characteristics**
Registration	• Recognise preferred names, pronouns, and address persons as who they are. • Healthcare workers treat patients/clients as who they are, without gossiping behind or offensively staring.	• Calling by birth or non-preferred names, disrespect to pronouns, and addressing with judgment. • Healthcare workers gossip behind and stare in judgmental ways.
Consultation	• Respect for diversity, sensitivity to needs, and language. • Healthcare workers are sensitized and prepared with a certain level of knowledge, and familiarity with the needs of transgender people with their intersections. • Match the treatment approach, specific to the patient/client. • Focus on promoting health and well-being, and not solely the "gender dysphoria." • Shared clinical decision-making made in the interest of the patient/client.	• Minimum, or no respect for diversity. • Healthcare workers are not gender and culturally sensitive to the needs of transgender people. • Gatekeeping practices that halt the process of affirmative care. • Inappropriate examinations without proper indication, for example, genital examination out of "curiosity." • Focus relies solely on gender; and gender diversity is considered a disorder, therefore needs to be repaired, or returned to a "normal" state. • Clinical decision-making made in the interest of the provider.
End of consultation	Patients/clients feel that their needs are addressed and secure enough to return to care and receive more follow-ups in the future.	Patients/clients feeling unhappy and disappointed with the care received; might not return to care or have future anticipated fear of discrimination.

EXAMPLES OF POSSIBLE ROLES IN HEALTHCARE SETTINGS

- Healthcare workers (those who work in healthcare settings): doctors, psychologists, nurses, midwives, laboratory technicians, administrative workers, radiology technicians, health security guards, and more.
- Patients-related: patients/clients, parents, children, spouse/partner, friends, and other family members.
- Community support: community leaders, coordinators, peer supports, and more.
- Other support: legal support, education support, and more.

4. After the drama session, ask the participants to share their thoughts, reflections, and feedback with the other team.
5. Explain briefly about the context of gender affirming care, examples, and practical approaches.

GENDER AFFIRMING CARE

Gender-affirming care, as defined by the World Health Organization, encompasses a range of social, psychological, medical, and surgical interventions "designed to support and affirm an individual's gender identity" when it conflicts with the gender they were assigned at birth (WHO Europe, n.d.). The intervention might vary person-to-person, and align with multiple aspects of the life continuum, from counseling, hormonal therapy, surgeries, and more. Gender identity, as noted by the American Psychiatric Association (APA), runs along a continuum of being a man, woman, combination of those, neither of those, and fluid. For the younger population, sometimes the goal is not treatment, but listening to the child and building understanding, creating a safe environment to safely explore their inner self (Boyle, 2022).

Attaining cultural humility with the full appreciation of the intersectionality of humanity is an ultimate educational goal." - WPATH, SOC-8

Examples of gender-affirming care (Boyle, 2022; Coleman et al., 2022; Deutsch, 2016):

1. Psychosocial counseling to support the transition process, in line with hormonal therapy.
2. Hormonal therapy to masculinize or feminize features.
3. Surgical interventions
    a. Specific to transgender and gender diverse population (e.g., feminizing vaginoplasty, orchiectomy, masculinizing phalloplasty/scrotoplasty, metoidioplasty; clitoral release/enlargement, may include urethral lengthening, masculinizing chest surgery ("top" surgery), facial feminization procedures, reduction thyrochondroplasty (tracheal cartilage shave), voice surgery).
    b. Not specific to transgender and gender diverse populations (e.g., breast augmentation mammoplasty, hysterectomy/oophorectomy, orchiectomy, vaginectomy
4. Other interventions (e.g., voice coaching or speech therapy, fertility preservation, laser hair removal, chest binding, genital tucking, and more).

6. Discuss the barriers and negative experiences of transgender individuals in accessing care. Address gatekeeping processes that historically halt the process of affirming care; therefore, potentially being harmful. Also, give some examples of things people say or do to a transgender person that might come in a negative light, either consciously or not, especially in the context of health.

EXAMPLES OF BARRIERS TO CARE

- Healthcare avoidance due to anticipated discrimination among transgender people is common. Using the 2015 U.S. Transgender Survey (19,157 transgender adults aged 25 to 64), almost one-quarter of the sample (22.8%) avoided healthcare due to anticipated discrimination (Kcomt et al., 2020).
- Negative interactions with healthcare professionals are also common, especially for those who pursue gender affirming care. For example, from a cross-sectional online survey of 1684 TGE people assigned female or intersex at birth in the US, around 70.1% of respondents (n = 1180) reported at least one negative interaction with an HCP in the past year, ranging from an unsolicited harmful opinion about gender identity to physical attacks and abuse. Those who had pursued gender affirming care (51.9% of the sample, n = 874) had 8.1 times the odds (95% CI: 4.1–17.1) of reporting any negative interaction with an HCP in the past year, compared to those who had not pursued gender-affirming care, and tended to report

EXAMPLES OF GATEKEEPING (ASHLEY, 2019; TRANSHUB, N.D.; VERBEEK ET AL., 2022**)**

- Refusing to take on trans or gender diverse patients and clients.
- Engaging conversion therapy (Trispiotis & Purshouse, 2021); any efforts to change sexuality or gender identity/expression.
- Requiring unnecessary steps in order to access gender affirmation, e.g. mandating a psychiatrist or endocrinologist assessment for all patients.
- Delaying gender affirming care without a clear health-based reason, or for reasons of “watchful waiting.”
- Not providing all the information or answers as to why a particular decision has been made.
- Requiring trans and gender diverse people to adopt a binary identity, or refusing to accept or learn about non-binary identities.
- Requiring invasive and unnecessary examinations or testing in order to access care.
- Discussion of rapid onset gender dysphoria (Ashley, 2020); proposed as a subtype of gender dysphoria and said to be caused by peer influence and social contagion.
- Over-inflation of regret rates.

EXAMPLES OF DISCOURAGING COMMENTS

"You look beautiful! You do not look trans!"
"When will you repent?"
"Oh, you don't want surgery! You will regret and turn back into being a man or woman again!"
"Have you never tried being a man (or woman), maybe you just have not found the right husband or wife to change you."
"We cannot treat you because it is against our moral (or religious) values."
"Let's get you tested for HIV now, you must have HIV."
"Oh, you are a top, you can still be 'cured'."

7. Give some tips on how to make healthcare more inclusive and acceptable to transgender and gender diverse people.

QUICK TIPS FOR HEALTHCARE WORKERS: TRANSCARE APPROACH
(UNIVERSITY OF IOWA HEALTH CARE, 2017)

- **T**reat transgender individuals with respect, as you would for all of your patients.
- **R**efer to transgender people by the name and pronoun associated with their gender identity.
- **A**sk politely how they wish to be addressed if you are unsure about a person's gender identity.
- **N**ever reveal a person's transgender status, unless it is absolutely necessary for the patient's health.
- **S**et a high standard for inclusive care.
- **C**oncentrate on care, not curiosity. For example: it is inappropriate to ask about genital status if it is unrelated to care.
- **A**void negative facial reactions and offensive language.
- **R**emember that treating a transgender patient is not always a training opportunity.
- **E**ducate yourself and others about transgender health care and issues.

Illustration on gender affirming care

8. Finalize by explaining the possible needs of transgender people in the healthcare setting.

SUMMARIZING THE POSSIBLE NEEDS OF TRANSGENDER AND GENDER DIVERSE PEOPLE IN THE HEALTHCARE SETTING

1. General health,
2. Mental health,
3. Transition-related, gender-affirming care (e.g. hormonal therapy, surgical interventions, social support on transition),
4. Sexual-reproductive health (HIV/STIs, anal-oral-genital sexual health, fertility health, contraception, pregnancy),
5. Other health-social-legal support (school, work employment, family, changing name and/or legal gender marker).

Activity 8: Linking evidence into action: I want to learn more!

Objective	• To understand core principles of being evidence-based in work and practice. • To understand how to find evidence and information related to transgender health and its intersections.
Estimated time	80 minutes.
Tools	Internet, laptop or phone, and PowerPoint presentation.
Method	Reflection, presentation, discussion, and sharing.
Online alternative	For online users of the training manual, this activity can be adapted as above by asking the participants to present their work through video conversation. Divide participants into breakout rooms during the preparation time.

Steps

1. Divide the participants into 4-5 groups to discuss several statements and opinions related to transgender health and rights, for examples:
   a. Transgender people spread HIV,
   b. Being transgender is a mental disorder,
   c. There are extremely high rates of regret for transgender people transitioning,
   d. Gender non-conforming people should be converted to “normal” and prevent them from turning into transgender,
   e. Transgender people change their legal gender marker to avoid crime, or do crime.
2. Ask participants to gather evidence around the transgender health-related statements and opinions. Give information about the hierarchy of evidence and evidence-based decision-making. Information gathered could be based on the websites listed in the references. However, it could be based on other credible sources as well.

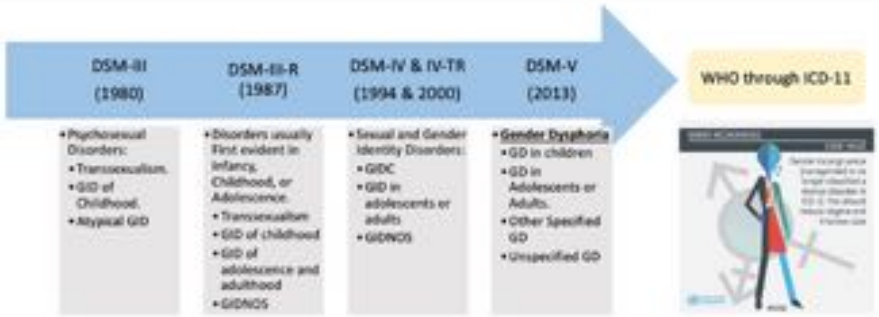
Looking at data and evidence (Akobeng, 2005; M Hassan Murad et al., 2016)

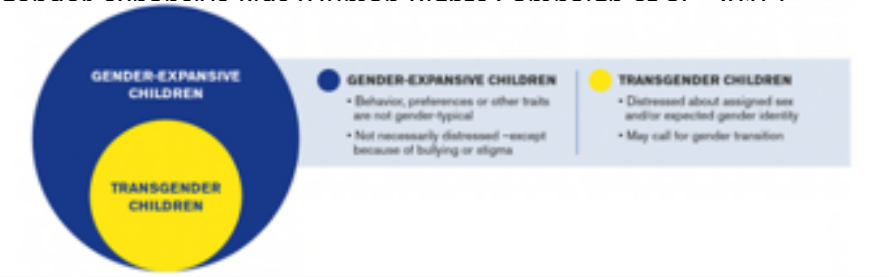
Moving forward to decision-making: Evidence-based practice (Jacobs, 2012)

3. Participants should create 1-2 paragraphs or several bullet points to explain the evidence-based information on several statements listed. Allow participants to share the information gathered with other team members.
4. Participants can investigate statements and opinions that might not be designated for their team. Ask participants for comments or input on whether their readings resonate with the evidence presented by the presenting team. Please encourage participants to remain respectful even if they have differing opinions.
5. Always point out the best available evidence of the interest of the transgender community; reflecting on the human rights-based approach to health.

Statement and opinion	Example of evidence information[1]
Transgender people spread HIV	Globally, transgender people are around 13 times more likely to be HIV-positive than other adults of reproductive age. In some regions, transgender women account for disproportionally large shares of new infections, particularly in Asia and the Pacific region (7%). Transgender people who are HIV positive and not being treated with ARV will have the risk of passing HIV. However, this is not exclusively because they were trans (UNAIDS, 2022a; WHO, n.d.). Transgender people, especially transgender women, are vulnerable to HIV and other STIs, due to structural and interpersonal discrimination. This could come in the form of survival sex work and other disparities. The prevalence of transgender women having HIV ranged from 17.7 to 21.6%, with transgender female sex workers being even more at-risk, with an estimated HIV prevalence of 27.3% (Baral et al., 2013; Operario et al., 2008). Additionally, transgender people were over four times more likely than cisgender people to be victims of violent crime (Flores et al., 2021). History of sexual violence is common among transgender people, particularly transgender women, in specific to being HIV positive, doing sex work, or being trans women of color due to intersecting marginalization (White Hughto et al., 2015). During the IAS 2023 conference, WHO released a strong statement that there is ZERO transmission risk once someone goes undetected. This should serve as a clear message to destigmatize key populations, including the transgender community (IAS Society, 2023; WHO, 2023a).
Being transgender is a mental disorder	Historically, Magnus Hirschfield is credited as among the first physicians to distinguish between same-sex attraction and "transsexualism." Followed by David Cauldwell (1949), who proposed one of the earliest diagnostic conceptualizations related to gender identity with the term "psychopathia transsexulialis." In 1966, Harry Benjamin published his foundational text "The Transsexual Phenomenon" and is credited with popularizing the term transsexual as it is used today, educating medical professionals about transgender people, and pioneering hormonal treatments to facilitate gender transition (APA, n.d.; Drescher, 2010).

Being transgender is a mental disorder	Despite increased attention to transgender people, the first two editions of DSM contained no mention of gender identity. It was not until 1980, with the publication of DSM–III, that the diagnosis "transsexualism" first appeared. In 1990, the World Health Organization followed suit and included this diagnosis in ICD-10. With the release of DSM–IV in 1994, "transsexualism" was replaced with "gender identity disorder in adults and adolescents" in an effort to reduce stigma. However, controversy continued, with advocates and some psychiatrists pointing to ways in which this diagnostic category still pathologized the identity (APA, n.d., 2013; Drescher, 2010). With the publication of DSM–5 in 2013, "gender identity disorder" was eliminated and replaced with "gender dysphoria." This change further focused the diagnosis on the gender identity-related distress that some transgender people experience (and for which they may seek psychiatric, medical, and surgical treatments) rather than on transgender individuals or identities themselves. The presence of gender variance is not the pathology but dysphoria is from the distress caused by the body and mind not aligning and/or societal marginalization of gender-variant people (ego-dystonic). The DSM–5 articulates explicitly that "gender non-conformity is not in itself a mental disorder." The 5th edition also includes a separate "gender dysphoria in children" diagnosis and, for the first time, allows the diagnosis to be given to individuals with disorders of sex development (DSD). DSM–5 also includes the optional "post-transition" specifier to indicate when a particular individual's gender transition is complete. In this "post-transition" case, the diagnosis of gender dysphoria would no longer apply but the individual may still need ongoing medical care (e.g., hormonal treatment) (APA, n.d., 2013; Drescher, 2010). Furthermore, the 11th edition of the International Statistical Classification of Diseases and Related Health Problems (ICD-11) has redefined gender identity-related health, replacing outdated diagnostic categories like ICD-10's "transsexualism" and "gender identity disorder of children" with "gender incongruence of adolescence and adulthood" and "gender incongruence of childhood", respectively. Gender incongruence was moved out of the "Mental and behavioral disorders" chapter and into the new "Conditions related to sexual health" chapter. This shifts reflects current knowledge that gender diverse identities are not conditions of mental ill-health and that classifying them as such can cause more stigma.

Being transgender is a mental disorder	The inclusion of gender incongruence in the ICD-11 should ensure transgender people's access to gender-affirming healthcare, as well as adequate health access (WHO, 2019). Nevertheless, discussions continue among advocates and medical professionals about how best to preserve access to gender transition-related health care while also minimizing the degree to which such diagnostic categories stigmatize the very people that healthcare workers want to support.  The transgender "diagnosis" (APA, 2013; F. Beek et al., 2016; WHO, 2019) Lastly, WHO is set to publish a guideline on the health of transgender and gender diverse people, incorporating scientific excellence with community engagement. The guideline is set to be published in 2024 (WHO, 2023b)
There are extremely high rates of regret for transgender people transitioning	Providing gender affirming medical and surgical support to trans and gender diverse people with persistent gender incongruence has been associated with low rates of regret and high rates of satisfaction (Coleman et al., 2022; Nieder et al., 2021). A 2021 published systematic review and meta-analysis of prevalence confirmed that the regret rate for gender affirmation surgeries was <1% (Bustos et al., 2021). In another latest long-term cross-sectional study of 139 survey respondents who underwent gender-affirming mastectomy, the median satisfaction score was 5 on a 5-point scale (higher scores indicating higher satisfaction), and the median decisional regret score was 0 on a 100-point scale (lower scores indicating lower levels of regret) (Bruce et al., 2023). However, while the ICD-11 requires the presence of marked and persistent gender incongruence for a diagnosis of gender incongruence to be made, there is little specific evidence regarding the length of persistence required for treatment in adults. Healthcare providers involved in an assessment of trans and gender diverse patients/clients are encouraged to give proper consideration to the life stage, history, and current circumstances of the adult being assessed (Coleman et al., 2022).

There are extremely high rates of regret for transgender people transitioning	In relation to the younger population, children or adolescents may express gender differently, some can express beyond the traditional gender norms, such as a boy who prefers dolls and dress-up play, or a girl who wears short hair and refuses skirts. They could be described as gender expansive, gender explorative, or gender creative. Most gender-expansive children are comfortable with the sex they were assigned at birth. They simply do not conform to the stereotypes that the people around them hold for that sex. But occasionally, a child consistently asserts a gender identity inconsistent with the sex they were assigned at birth. These children may also express discomfort with their sex, such as a desire to be rid of their genitals or a wish that they had been "born in a different body." They will often say "I am…" rather than "I wish I were…" Children and adults who identify with a gender and/or sex different than what they were assigned at birth are known as transgender. Transgender children are a subset of gender expansive kids (Human Rights Campaign et al., 2016)  Gender expansiveness (Human Rights Campaign et al., 2016) Signs of gender expansiveness can emerge at any age. Generally, in one survey, parents and caregivers of transgender youth first noticed these signs at an average age of 4½, whereas the kids themselves started articulating their distinct gender identity near the age of 6. Nonetheless, many transgender people don't express (or even understand) their gender identity until they are teens or adults. The general rule for determining whether a child is transgender or non-binary (rather than gender nonconforming or gender variant) is if the child is consistent, insistent, and persistent about their transgender identity (Human Rights Campaign et al., 2016; Steensma et al., 2013). Some children are socially transitioning to live congruently with their gender identity (such as using certain pronouns, names, hairstyles, and clothes). There have been various concerns expressed about social transitions in childhood, including the possibility that these children might not maintain a transgender identity and may subsequently "retransition" (also termed "detransition" or "desistence").

There are extremely high rates of regret for transgender people transitioning	Research indicates that the age range of 10 to 13 years might be a particularly pivotal time for retransition, and identity might solidify after this stage for youth who exhibit early gender nonconformity (Steensma et al., 2011). A recent study by Olson, et al. indicated that typically, transgender youth who socially transitioned at younger ages persist in identifying in the same manner; of 317 initially transgender youth (208 transgender girls, 109 transgender boys; mean = 8.1 years at start of study) participating in a longitudinal study, found that only 7.3% of youth had retransitioned at least once at an average of 5 years after their initial social transition. Turns out, most youth identified as binary transgender youth (94%), including 1.3% who retransitioned to another identity before returning to their binary transgender identity, and a total of 2.5% of youth identified as cisgender and 3.5% as nonbinary (Olson et al., 2022). Reasons leading to "detransition" among transgender and gender-diverse individuals are multifaceted. A secondary analysis from the U.S. Transgender Survey (with 17,151 or 61.9% participants noting they had sought gender affirmation at some point) found that 13.1% reported a history of detransition, with 82.5% reported at least one external driving factor, including pressure from family and societal stigma. History of detransition was associated with male sex assigned at birth, nonbinary gender identity, bisexual sexual orientation, and having a family unsupportive of one's gender identity.Additionally, 15.9% of respondents cited at least one internal motivating factor, which encompassed variations in or doubts about gender identity (Turban et al., 2021).
Gender non-conforming people should be converted to “normal” and prevent them from turning into transgender	Gender diversity is not considered as a mental disorder under DSM-5 and ICD-11 (APA, 2013; WHO, 2019). According to the Office of the High Commissioner for Human Rights or the United Nations Human Rights Office (OHCHR), conversion therapy is an umbrella term used to describe interventions of a wide-ranging nature, all of which have in common the belief that a person's sexual orientation or gender identity can and should be changed. Conversion therapy oftentimes came in organized and sustained efforts to avoid the adoption of non-heterosexual sexual orientations and/or of gender identities not assigned at birth (Alempijevic et al., 2020; OHCHR, 2020).

There are extremely high rates of regret for transgender people transitioning	Conversion therapy is a pseudoscientific practice using psychological, physical, or spiritual interventions. There is no evidence that sexual orientation and gender identity can be changed. Medical institutions warn that conversion therapy practices are ineffective and harmful, including the WHO and the American Psychiatric Association (APA). Conversion therapy is banned in various countries around the world and potentially brings harm to the well-being of patients/clients (Minnesota Department of Health, 2022; Trispiotis & Purshouse, 2021). Several approaches in conversion therapy or efforts (OHCHR, 2020): 1. Psychotherapy: Interventions based on the belief that sexual or gender diversity is a product of an abnormal upbringing or experience (e.g., talk therapy, psychodynamic, behavioral, cognitive, interpersonal therapies, and more). A recurrent method used is aversion (e.g., electric shocks, nausea-inducing or paralysis-inducing drugs) through which a person is subjected to a negative, painful or otherwise distressing sensation while being exposed to a certain stimulus connected to their sexual orientation. 2. Medical: Practices rooted on the postulation that sexual or gender diversity is an inherent biological dysfunction (e.g., pharmaceutical approaches, such as medication, hormone or steroid therapy for "chemical castration" and surgical approaches; in the Islamic Republic of Iran, individuals who inevitably fail at "converting" their sexual orientation will often be pressured to undergo gender-affirming surgery, in the belief that it will neutralize their orientation). 3. Faith-based: Interventions that act on the premise that there is something inherently evil in diverse sexual orientations and gender identities. Victims are usually submitted to the tenets of a spiritual advisor and subjected to programmes to overcome their "condition" (such programmes can include anti-gay slurs as well as beatings, shackling, food deprivation, and exorcism). Other efforts of conversion therapy could be done structurally through discriminative policies and cultural practices. For example, violent raids that consist of shaming, hair cutting, and stripping people naked, with the main target of transgender women and gay men; or certain character-building efforts to convert people back to "normal" (e.g. Indonesian social rehabilitation program targeting people with social welfare problems and those with immoral lifestyle) (Halim, 2021). Corrective rape is a horrifying use of sexual assault to try and force someone to feel heterosexual attraction (Minnesota Department of Health, 2022).

Transgender people change their legal gender marker to avoid crime, or do crime against women	Transgender people choose to change their name and legal gender marker to better align their social identity and how they represent themselves to the world. In reality, legal gender markers and name changes are associated with a lower negative emotional response to gender-based mistreatment and improve mental health outcomes among trans populations (Restar et al., 2020). There is no data that transgender people change their legal gender marker for malicious intentions. Statistically, transgender people are more likely to become victims of crime, including violence, abuse, victimization, and criminalization (Flores et al., 2020). Data from the 2015 U.S. Transgender Survey showed that 46% of respondents were verbally harassed and 9% were physically attacked in the past year because of being transgender. Nearly half (47%) of respondents were sexually assaulted at some point in their lifetime, with higher rates among black respondents (53%) and those with disabilities (61%).More than half (54%) experienced some form of intimate partner violence, including acts involving coercive control and physical harm(James et al., 2016; VAWnet, n.d.)

6. Explain to the participants regarding the best available resources regarding the health and rights of young transgender and gender non-conforming people, for example, WPATH's standards of care (8th edition), APTN's "Towards transformative healthcare: Asia Pacific trans health and rights module," WHO's "Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations," American Academy of Family Physicians (AAFP)'s publication guidance, and other sources.

EXAMPLE 1: WPATH'S GUIDELINE - "STANDARDS OF CARE FOR THE HEALTH OF TRANSGENDER AND GENDER DIVERSE PEOPLE, VERSION 8"

Standards of Care for the Health of Transgender and Gender Diverse People, Version 8

The World Professional Association for Transgender Health (WPATH) champions evidence-based care and standards in transgender health. Its core document, the Standards of Care (SOC), which was first introduced in 1979, had its last update in 2012 as SOC-7. Given the evolving knowledge, WPATH released a new version, the SOC-8. This updated version aims to guide healthcare professionals in offering safe and effective care for TGD individuals, enhancing their overall well-being and health. The SOC-8, crafted from systematic literature reviews and expert opinions, comprises 18 chapters, encompassing general areas of transgender health and specifics of gender-affirming treatments, namely: terminology, global applicability, population estimates, education, assessment of adults, adolescents, children, nonbinary, eunuchs, intersex, institutional environments, hormone therapy, surgery and postoperative care,voice and communication, primary care, reproductive health, sexual health, mental health. These guidelines are designed for global adaptability and primarily serve as a foundation for best practices in treating gender incongruence (Coleman et al., 2022).

Examples of recommendations from WPATH SOC-8, on global applicability (chapter 2) and assessment of adults (chapter 5):

STATEMENTS OF RECOMMENDATIONS

2.1- We recommend health care systems should provide medically necessary gender-affirming health care for transgender and gender diverse people
2.2- We recommend health care professionals and other users of the Standards of Care, Version 8 (SOC-8) apply the recommendations in ways that meet the needs of local transgender and gender diverse communities, by providing culturally sensitive care that recognizes the realities of the countries they are practicing in.
2.3- We recommend health care providers understand the impact of social attitudes, laws, economic circumstances, and health systems on the lived experiences of transgender and gender diverse people worldwide.
2.4- We recommend translations of the SOC focus on cross-cultural, conceptual, and literal equivalence to ensure alignment with the core principles that underpin the SOC-8.
2.5- We recommend health care professionals and policymakers always apply the SOC-8 core principles to their work with transgender and gender diverse people to ensure respect for human rights and access to appropriate and competent health care, including:

General principles

- Be empowering and inclusive. Work to reduce stigma and facilitate access to appropriate health care for all who seek it;
- Respect diversity. Respect all clients and all gender identities. Do not pathologize differences in gender identity or expression;
- Respect universal human rights including the right to bodily and mental integrity, autonomy and self-determination; freedom from discrimination, and the right to the highest attainable standard of health.

Principles around developing and implementing appropriate services and accessible health care

- Involve transgender and gender diverse people in the development and implementation of services;
- Become aware of social, cultural, economic, and legal factors that might impact the health (and health care needs) of transgender and gender diverse people, as well as the willingness and the capacity of the person to access services;
- Provide health care (or refer to knowledgeable colleagues) that affirms gender identities and expressions, including health care that reduces the distress associated with gender dysphoria (if this is present);
- Reject approaches that have the goal or effect of conversion and avoid providing any direct or indirect support for such

approaches or services.

Principles around delivering competent services

- Become knowledgeable (get training, where possible) about the health care needs of transgender and gender diverse people, including the benefits and risks of gender-affirming care;
- Match the treatment approach to the specific needs of clients, particularly their goals for gender identity and expression;
- Focus on promoting health and well-being rather than solely the reduction of gender dysphoria, which may or may not be present;
- Commit to harm reduction approaches where appropriate;
- Enable the full and ongoing informed participation of transgender and gender diverse people in decisions about their health and well-being;
- Improve experiences of health services including those related to administrative systems and continuity of care.

Principles around working towards improved health through wider community approaches

- Put people in touch with communities and peer support networks;
- Support and advocate for clients within their families and communities (schools, workplaces, and other settings) where appropriate.

STATEMENTS OF RECOMMENDATIONS

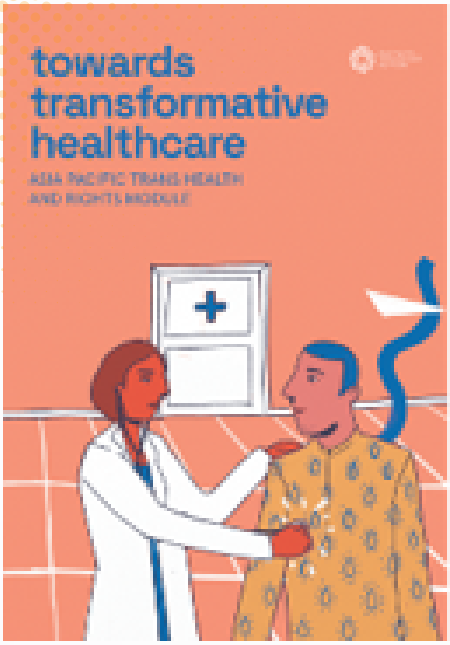
5.1- We recommend health care professionals assessing transgender and gender diverse adults for physical treatments:
5.1.a- Are licensed by their statutory body and hold, at a minimum, a master's degree or equivalent training in a clinical field relevant to this role and granted by a nationally accredited statutory institution.
5.1.b- For countries requiring a diagnosis for access to care, the health care professional should be competent using the latest edition of the World Health Organization's International Classification of Diseases (ICD) for diagnosis. In countries that have not implemented the latest ICD, other taxonomies may be used; efforts should be undertaken to utilize the latest ICD as soon as practicable.
5.1.c- Are able to identify co-existing mental health or other psychosocial concerns and distinguish these from gender dysphoria, incongruence, and diversity.
5.1.d- Are able to assess capacity to consent for treatment.
5.1.e- Have experience or be qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity.
5.1.f- Undergo continuing education in health care relating to gender dysphoria, incongruence, and diversity.
5.2- We suggest health care professionals assessing transgender and gender diverse adults seeking gender-affirming treatment liaise with professionals from different disciplines within the field of transgender health for consultation and referral, if required.

The following recommendations are made regarding the requirements for gender-affirming medical and surgical treatment (all should be met):

5.3- We recommend health care professionals assessing transgender and gender diverse adults for gender-affirming medical and surgical treatment:
5.3.a- Only recommend gender-affirming medical treatment requested by a TGD person when the experience of gender incongruence is marked and sustained.
5.3.b- Ensure fulfillment of diagnostic criteria prior to initiating gender-affirming treatments in regions where a diagnosis is necessary to access health care.
5.3.c- Identify and exclude other possible causes of apparent gender incongruence prior to the initiation of gender-affirming treatments.
5.3.d- Ensure that any mental health conditions that could negatively impact the outcome of gender-affirming medical treatments are assessed, with risks and benefits discussed, before a decision is made regarding treatment.
5.3.e- Ensure any physical health conditions that could negatively impact the outcome of gender-affirming medical treatments are assessed, with risks and benefits discussed, before a decision is made regarding treatment.
5.3.- Assess the capacity to consent for the specific physical treatment prior to the initiation of this treatment.
5.3.g- Assess the capacity of the gender diverse and transgender adult to understand the effect of gender-affirming treatment on reproduction and explore reproductive options with the individual prior to the initiation of gender-affirming treatment.

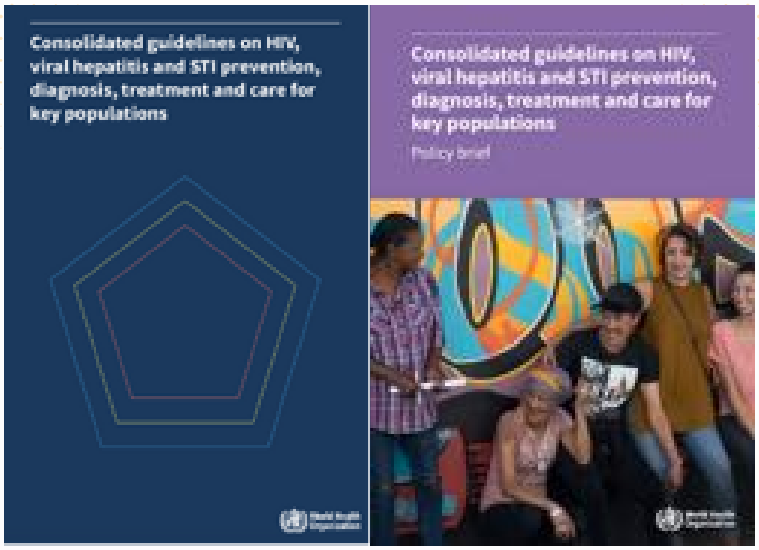
5.4- We suggest, as part of the assessment for gender-affirming hormonal or surgical treatment, professionals who have competencies in the assessment of transgender and gender diverse people wishing gender-related medical treatment consider the role of social transition together with the individual.
5.5- We recommend transgender and gender diverse adults who fulfill the criteria for gender-affirming medical and surgical treatment require a single opinion for the initiation of this treatment from a professional who has competencies in the assessment of transgender and gender diverse people wishing gender-related medical and surgical treatment.
5.6- We suggest health care professionals assessing transgender and gender diverse people seeking gonadectomy consider a minimum of 6 months of hormone therapy as appropriate to the GD person's gender goals before the GD person undergoes irreversible surgical intervention (unless hormones are not clinically indicated for the individual).
5.7- We recommend health care professionals assessing adults who wish to detransition and seek gender-related hormone intervention, surgical intervention, or both, utilize a comprehensive multidisciplinary assessment that will include additional viewpoints from experienced health care professional in transgender health and that considers, together with the individual, the role of social transition as part of the assessment process.

EXAMPLE 2: APTN'S PUBLICATION - "TOWARDS TRANSFORMATIVE HEALTHCARE: ASIA PACIFIC TRANS HEALTH AND RIGHTS MODULE"



APTN's trans health and rights module offers an essential guide on trans competent and gender-affirming healthcare tailored for medical professionals and healthcare workers in Asia and the Pacific, especially those in primary and community-based care. The self-paced, interactive module encompasses 12 comprehensive topics ranging from regional gender diversity, creating an inclusive environment for trans patients, to specific healthcare concerns like mental health, sexual and reproductive health, and gender-affirming care. For more information about the module and online source, you can check the link here and here (Byrne, 2022).

EXAMPLE 3: WHO'S PUBLICATION - "CONSOLIDATED GUIDELINES ON HIV, VIRAL HEPATITIS AND STI PREVENTION, DIAGNOSIS, TREATMENT AND CARE FOR KEY POPULATIONS"



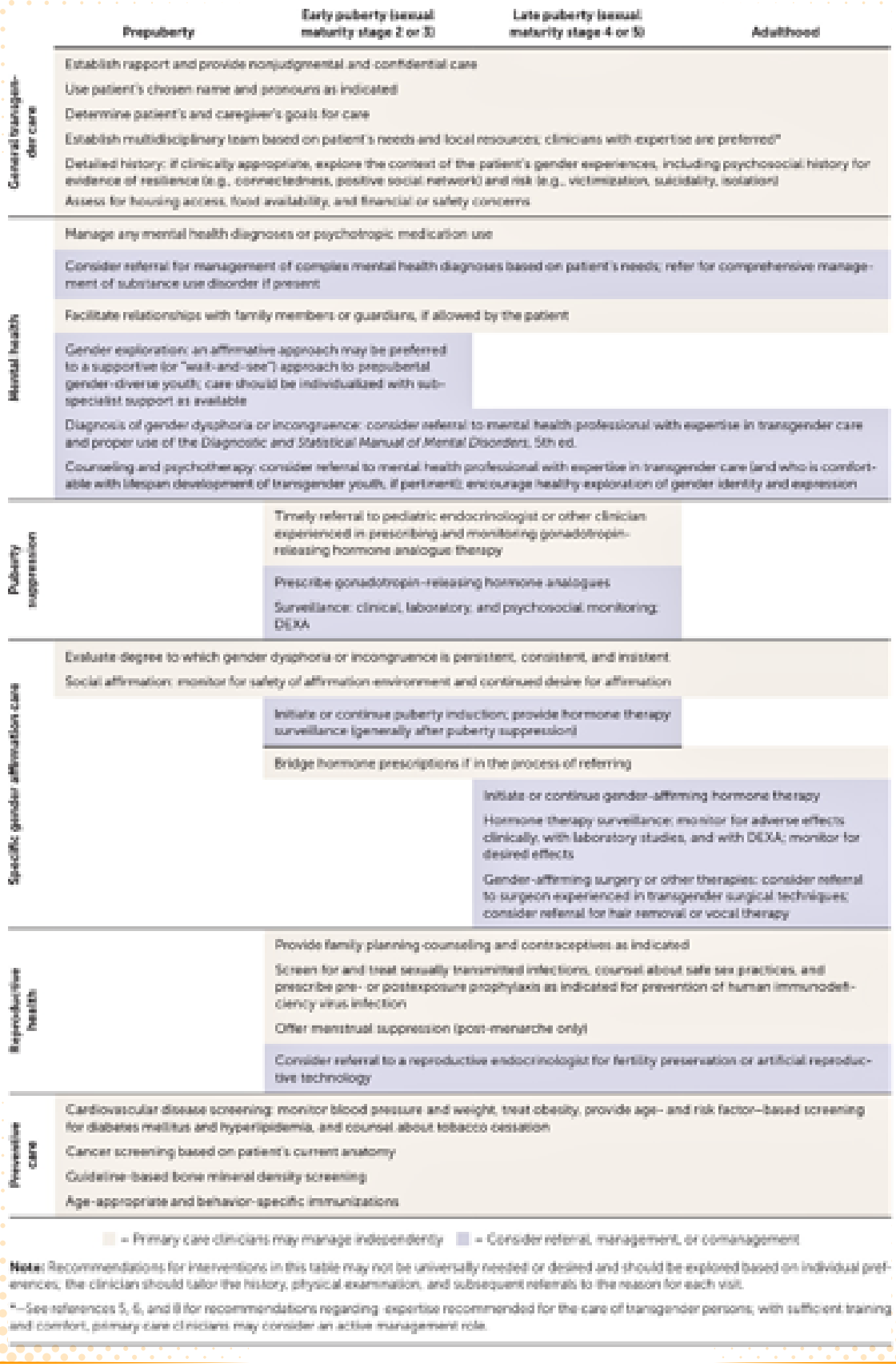
The consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations outline a public health response for 5 key populations (men who have sex with men, trans and gender diverse people, sex workers, people who inject drugs, and people in prisons and other closed settings). This guideline emphasize addressing structural barriers that increase vulnerability and hinder access to essential services for these key populations. Despite the importance, many countries still provide inadequate or low-quality services to these groups. It's essential for countries to prioritize these key populations and allow their communities to spearhead the response, ensuring they receive equitable and appropriate services for all (WHO, 2022a, 2022b).

Essential for impact: enabling interventions	Essential for impact: health interventions	Essential for broader health: health interventions
• Removing punitive laws, policies and practices • Reducing stigma and discrimination • Community empowerment • Addressing violence	**Prevention of HIV, viral hepatitis and STIs** • Condoms and lubricant • PrEP for HIV • PEP for HIV and STIs • Prevention of vertical transmission of HIV, syphilis and HBV • HBV vaccination • Addressing chemsex **Diagnosis** • HIV testing services • STI testing • HBV and hepatitis C (HCV) testing **Treatment** • HIV treatment • Screening, diagnosis, treatment and prevention of HIV-associated tuberculosis (TB) • STI treatment • HBV and HCV treatment	• Anal health • Conception and pregnancy care • Contraception • Gender-affirming care • Mental health • Prevention, assessment and treatment of cervical cancer • Safe abortion • Screening and treatment for hazardous and harmful alcohol and other substance use

For example, a comprehensive package of services is recommended to address the needs of transgender people in the context of infectious diseases (WHO, n.d.)

EXAMPLE 4: GUIDANCE FROM THE AMERICAN ACADEMY OF FAMILY PHYSICIANS (AAFP) - "CARING FOR TRANSGENDER AND GENDER-DIVERSE PERSONS: WHAT CLINICIANS SHOULD KNOW"

Several other healthcare associations and bodies, such as the American Academy of Family Physicians, provide proper evidence and have their own guidance.



	Prepuberty	Early puberty (sexual maturity stage 2 or 3)	Late puberty (sexual maturity stage 4 or 5)	Adulthood
General transgender care	Establish rapport and provide nonjudgmental and confidential care			
	Use patient's chosen name and pronouns as indicated			
	Determine patient's and caregiver's goals for care			
	Establish multidisciplinary team based on patient's needs and local resources; clinicians with expertise are preferred*			
	Detailed history: if clinically appropriate, explore the context of the patient's gender experiences, including psychosocial history for evidence of resilience (e.g., connectedness, positive social network) and risk (e.g., victimization, suicidality, isolation)			
	Assess for housing access, food availability, and financial or safety concerns			
Mental health	Manage any mental health diagnoses or psychotropic medication use			
	Consider referral for management of complex mental health diagnoses based on patient's needs; refer for comprehensive management of substance use disorder if present			
	Facilitate relationships with family members or guardians, if allowed by the patient			
	Gender exploration: an affirmative approach may be preferred to a supportive (or "wait-and-see") approach to prepubertal gender-diverse youth; care should be individualized with subspecialist support as available			
	Diagnosis of gender dysphoria or incongruence: consider referral to mental health professional with expertise in transgender care and proper use of the *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed.			
	Counseling and psychotherapy: consider referral to mental health professional with expertise in transgender care (and who is comfortable with lifespan development of transgender youth, if pertinent); encourage healthy exploration of gender identity and expression			
Puberty suppression		Timely referral to pediatric endocrinologist or other clinician experienced in prescribing and monitoring gonadotropin-releasing hormone analogue therapy		
		Prescribe gonadotropin-releasing hormone analogues		
		Surveillance: clinical, laboratory, and psychosocial monitoring; DEXA		
Specific gender affirmation care	Evaluate degree to which gender dysphoria or incongruence is persistent, consistent, and insistent			
	Social affirmation: monitor for safety of affirmation environment and continued desire for affirmation			
		Initiate or continue puberty induction; provide hormone therapy surveillance (generally after puberty suppression)		
		Bridge hormone prescriptions if in the process of referring		
			Initiate or continue gender-affirming hormone therapy	
			Hormone therapy surveillance: monitor for adverse effects clinically, with laboratory studies, and with DEXA; monitor for desired effects	
			Gender-affirming surgery or other therapies: consider referral to surgeon experienced in transgender surgical techniques; consider referral for hair removal or vocal therapy	
Reproductive health		Provide family planning counseling and contraceptives as indicated		
		Screen for and treat sexually transmitted infections, counsel about safe sex practices, and prescribe pre- or postexposure prophylaxis as indicated for prevention of human immunodeficiency virus infection		
		Offer menstrual suppression (post-menarche only)		
		Consider referral to a reproductive endocrinologist for fertility preservation or artificial reproductive technology		
Preventive care	Cardiovascular disease screening: monitor blood pressure and weight, treat obesity, provide age- and risk factor–based screening for diabetes mellitus and hyperlipidemia, and counsel about tobacco cessation			
	Cancer screening based on patient's current anatomy			
	Guideline-based bone mineral density screening			
	Age-appropriate and behavior-specific immunizations			

= Primary care clinicians may manage independently = Consider referral, management, or comanagement

Note: Recommendations for interventions in this table may not be universally needed or desired and should be explored based on individual preferences; the clinician should tailor the history, physical examination, and subsequent referrals to the reason for each visit.

*—See references 5, 6, and 8 for recommendations regarding expertise recommended for the care of transgender persons; with sufficient training and comfort, primary care clinicians may consider an active management role.

Considerations in primary care: Transgender and gender-diverse people (Klein et al., 2018)

7. Close the session by encouraging participants to do more learning and reading, linking the needs of the transgender and gender diverse population to getting the highest attainable quality of care.

Activity 9: Closing, reflection, and future action plans

Objective	To close the workshop session and share reflections, along with future plans.
Estimated time	20 minutes.
Tools	Laptop or phone.
Method	Survey, discussion, and sharing.
Online alternative	If the workshop is conducted virtually, ask the participants to share their reflections through video or voice chat. The online survey could be used to note the evaluation.

Steps:

1. In a short sharing session, ask the participants to share their self-reflection regarding the workshop and future plans they might have.
2. Ask participants to write down their self-reflections and input through a survey provided as part of their evaluation process. The survey should could include several key elements, such as goals, overall reflection, training module and materials, facilitation process, logistics, and accommodation, as well as future action plans.

EXAMPLE OF SURVEY QUESTIONS

Example of questions	Methods of answering
The goals set for the workshop were set and delivered throughout the process	Five-likert scale 1-5; strongly disagree to strongly agree
What would be your reflection throughout the training process?	Long text answer
The training module and materials provided were relevant and useful to my professional work as a healthcare worker	Five-likert scale 1-5; strongly disagree to strongly agree
Do you have any feedback regarding the training module and materials provided?	Long text answer
I enjoy the facilitation process; I am able to gather valuable insights because of the facilitation process	Five-likert scale 1-5; strongly disagree to strongly agree
Do you have specific recommendations regarding the facilitation process?	Long text answer
The logistics and accommodation aspects of this workshop were suitable to my needs	Five-likert scale 1-5; strongly disagree to strongly agree
Do you have any input to the logistics and accommodation aspects?	Long text answer
I would recommend that my other colleagues to attend this workshop in the future	Five-likert scale 1-5; strongly disagree to strongly agree
What kind of future action plans do you have for yourself and/or your organization/institution after this workshop?	Long text answer

3. After the participants finished the survey and reflection, close the workshop session and thank all the participants for their contribution.

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ANNEX

Annex 1. Agenda template

Time	Activity	Notes
09.00-09.20 (20 mins)	Activity 1: Welcome introduction	
09.20-09.35 (15 mins)	Activity 2: Walls of hope	
09.35-09.50 (15 mins)	Activity 3: Establishing ground rules	
09.50-10.00 (10 mins)	Break	
10.00-10.45 (45 mins)	Activity 4: SOGIESC show: Understanding self, am I proud of being who I am?	
10.45-11.30 (45 mins)	Activity 5: Understanding intersectionality: What are our social identities?	
11.30-12.30 (60 mins)	Lunch	
12.30-13.45 (75 mins)	Activity 6: Recognizing challenges to health: Rights of young transgender and gender diverse people	
13.45-15.00 (75 mins)	Activity 7: Inclusive care and affirming services for young transgender people: History and current reality	
15.00-15.10 (10 mins)	Break	
15.10-16.30 (80 mins)	Activity 8: Linking evidence into action: I want to learn more!	
16.30-16.50 (20 mins)	Activity 9: Closing, reflection, and future action plans	

Youth LEAD

CERTIFICATE

OF ATTENDANCE

This is to certify that

.....

Has attended the workshop on "Delivering inclusive services for young transgender and gender diverse people: A workshop for healthcare workers"

DATE: _____

SIGNATURE, _____